South Haven Community Hospital Authority

Financial Report
June 30, 2008

South Haven Community Hospital Authority

Contents

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Independent Auditor's Report

To the Board of Directors
South Haven Community Hospital Authority

We have audited the accompanying balance sheet of South Haven Community Hospital Authority (the "Hospital") as of June 30, 2008 and 2007 and the related statements of revenues, expenses, and changes in net assets and cash flows for the years then ended. These financial statements are the responsibility of the Hospital's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of South Haven Community Hospital Authority at June 30, 2008 and 2007 and the results of its operations and its cash flows for the years then ended, in conformity with accounting principles generally accepted in the United States of America.

The accompanying financial statements do not present a management's discussion and analysis, which would be an analysis of the financial performance for the year. The Governmental Accounting Standards Board has determined that this analysis is necessary to supplement, although not required to be part of, the basic financial statements.

Plante & Moran, PLLC

September 5, 2008

South Haven Community Hospital Authority

Balance Sheet

	June 30, 2008	June 30, 2007
Assets		
Current Assets		
Cash and cash equivalents (Note 2)	$ 1,724,191	$ 1,706,142
Assets limited as to use (Note 2)	300,000	4,810,460
Accounts receivable (Note 3)	7,367,332	5,997,105
Other current assets	506,506	457,140
Total current assets	9,898,029	12,970,847
Assets Limited as to Use (Note 2)	8,291,961	10,937,609
Property and Equipment - Net (Note 4)	22,894,016	17,332,495
Total assets	**$ 41,084,006**	**$ 41,240,951**
Liabilities and Net Assets		
Current Liabilities		
Current portion of long-term debt (Note 7)	$ 1,045,978	$ 1,047,059
Accounts payable	729,796	1,343,005
Estimated third-party payor settlements (Note 5)	1,659,973	1,742,199
Retainage payable	72,106	51,943
Accrued liabilities and other (Note 6)	2,040,576	2,026,846
Total current liabilities	5,548,429	6,211,052
Long-term Debt - Net of current portion (Note 7)	9,415,519	10,467,247
Total liabilities	14,963,948	16,678,299
Net Assets		
Invested in capital assets - Net of related debt	12,432,519	10,328,649
Restricted for capital acquisitions	-	4,510,460
Unrestricted	13,687,539	9,723,543
Total net assets	26,120,058	24,562,652
Total liabilities and net assets	**$ 41,084,006**	**$ 41,240,951**

See Notes to Financial Statements.

South Haven Community Hospital Authority

Statement of Revenues, Expenses, and Changes in Net Assets

	Year Ended	
	June 30, 2008	June 30, 2007
Operating Revenues		
Net patient service revenue - Net of provision for bad debts of $3,831,000 in 2008 and $3,847,000 in 2007	$ 36,809,420	$ 33,055,910
Other	750,593	118,764
Total operating revenues	37,560,013	33,174,674
Operating Expenses		
Salaries and wages	15,181,776	13,004,137
Employee benefits and payroll taxes	4,449,709	3,440,298
Operating supplies	4,389,248	4,180,061
Professional services and consultant fees	3,130,379	2,328,873
Purchased services	2,669,229	3,112,969
Insurance	1,097,904	1,009,951
Utilities and maintenance	1,267,462	1,131,183
Other	1,461,940	511,050
Depreciation	2,801,266	2,439,878
Total operating expenses	36,448,913	31,158,400
Operating Income	1,111,100	2,016,274
Nonoperating Income (Note 10)	446,306	1,750,581
Increase in Net Assets	1,557,406	3,766,855
Net Assets - Beginning of year	24,562,652	20,795,797
Net Assets - End of year	**$ 26,120,058**	**$ 24,562,652**

See Notes to Financial Statements.

South Haven Community Hospital Authority

Statement of Cash Flows

	Year Ended June 30, 2008	Year Ended June 30, 2007
Cash Flows from Operating and Nonoperating Activities		
Cash received from patients and third-party payors	$ 35,356,967	$ 31,774,317
Cash payments to suppliers for services and goods	(33,685,225)	(28,219,922)
Other receipts from operations	750,593	118,764
Net cash provided by operating activities	2,422,335	3,673,159
Cash Flows from Noncapital Financing Activities		
Property taxes	373,415	372,240
Other nonoperating income	1,513	19,017
Net cash provided by noncapital financing activities	374,928	391,257
Cash Flows from Investing Activities		
Income received from investments	499,641	540,909
Rental receipts - Net of expenses paid	(9,003)	(46,915)
Purchases of assets limited as to use	(601,315)	(11,156,719)
Sales of assets limited as to use	7,570,914	5,830,365
Net cash provided by (used in) investing activities	7,460,237	(4,832,360)
Cash Flows from Capital and Related Financing Activities		
Acquisition and construction of capital assets	(9,184,995)	(2,715,599)
Receipt of pledges receivable	313,249	-
Proceeds from sale of capital assets	138,550	3,200
Issuance of long-term debt	-	4,500,000
Contributions restricted for capital expenditure	-	1,035,383
Interest paid on long-term debt	(453,446)	(309,638)
Principal payments on long-term debt	(1,052,809)	(577,852)
Net cash (used in) provided by capital and related financing activities	(10,239,451)	1,935,494
Net Increase in Cash and Cash Equivalents	18,049	1,167,550
Cash and Cash Equivalents - Beginning of year	1,706,142	538,592
Cash and Cash Equivalents - End of year	**$ 1,724,191**	**$ 1,706,142**

See Notes to Financial Statements.

South Haven Community Hospital Authority

Statement of Cash Flows (Continued)

A reconciliation of operating income to net cash from operating activities is as follows:

	Year Ended June 30, 2008	Year Ended June 30, 2007
Cash Flows from Operating Activities		
Operating income	$ 1,111,100	$ 2,016,274
Adjustments to reconcile operating income to net cash from operating activities:		
Depreciation	2,801,266	2,439,878
Provision for bad debts	3,831,360	3,847,367
Changes in assets and liabilities:		
Increase in patient accounts receivable	(5,201,587)	(5,186,155)
Increase in other current assets	(49,366)	(44,896)
Increase (decrease) in accounts payable	31,704	(213,999)
(Decrease) increase in third-party settlement payables	(82,226)	57,195
Increase in retainage payable	20,163	51,943
(Decrease) increase in other accrued expenses	(40,079)	705,552
Net cash provided by operating activities	**$ 2,422,335**	**$ 3,673,159**

Significant noncash investing, capital, and financing activities for 2008 and 2007 are as follows:

- Medical office building rent, net includes an allocation of depreciation expense, and totaled $40,691 and $67,236 in 2008 and 2007, respectively.
- The net increase in fair value of investments for the years ended June 30, 2008 and 2007 totaled $126,740 and $207,427, respectively.
- A gain (loss) on disposal of assets for the years ended June 30, 2008 and 2007 totaled $1,946 and ($606), respectively.
- During the year ended June 30, 2007, the Hospital entered into a capital lease agreement in the amount of $1,438,824.
- At June 30, 2007, $644,913 of construction in progress was included in accounts payable.

Note 1 - Nature of Business and Significant Accounting Policies

Reporting Entity - South Haven Community Hospital Authority (the "Hospital") is a short-term, acute-care facility offering inpatient and outpatient healthcare services primarily to citizens of South Haven, Michigan and several adjacent townships. The Hospital is organized pursuant to Public Act 47 of Public Act 5 of 1945. A significant portion of the Hospital's receivables relates to contractual arrangements with Medicare, Medicaid, and Blue Cross/Blue Shield programs.

Use of Estimates - The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the reporting period. Actual results could differ from those estimates.

Basis of Presentation - The financial statements have been prepared in accordance with generally accepted accounting principles as prescribed by Governmental Accounting Standards Board (GASB) Statement No. 34, *Basic Financial Statements - and Management's Discussion and Analysis - for State and Local Governments,* issued in June 1999. The Hospital follows the business-type activities reporting requirements of GASB Statement No. 34, which provide a comprehensive look at the Hospital's financial activities. No component units are required to be reported in the Hospital's financial statements.

Enterprise Fund Accounting - The Hospital uses Enterprise Fund accounting. Revenues and expenses are recognized on the accrual basis using the economic resources measurement focus. Based on Governmental Accounting Standards Board (GASB) Statement No. 20, *Accounting and Financial Reporting for Proprietary Fund Accounting,* as amended, the Hospital has elected to apply the provisions of all relevant pronouncements of the Financial Accounting Standards Board (FASB), including those issued after November 30, 1989, that do not conflict with or contradict GASB pronouncements.

Cash and Cash Equivalents - Cash and cash equivalents include cash and investments in highly liquid investments purchased with an original maturity of three months or less, excluding those amounts included in assets limited as to use.

Assets Limited as to Use - Assets limited as to use include assets designated by the board of trustees for future capital improvements, over which the board retains control, and may, at its discretion, subsequently use for other purposes. Included are also $700,000 of gross pledges receivable, with an allowance of $230,000 for potential uncollectibility.

Note 1 - Nature of Business and Significant Accounting Policies (Continued)

Investments - Investments in equity securities with readily determinable fair values and all investments in debt securities are measured at fair value in the balance sheet. Investment income or loss (including realized gains and losses on investments, interest, and dividends) is included in nonoperating income.

Property and Equipment - Property and equipment amounts are recorded at cost. Donations of property and equipment are recorded at fair market value at the date of donation. Depreciation is provided over the estimated useful life of each class of depreciable asset and is computed using the straight-line method. Costs of maintenance and repairs are charged to expense when incurred.

Compensated Absences - Compensated absences are charged to operations when they are earned. Unused benefits are recorded in accrued liabilities on the financial statements.

Classification of Net Assets - Net assets of the Hospital are classified in three components. Net assets invested in capital assets net of related debt consist of capital assets net of accumulated depreciation and reduced by the balances of any outstanding borrowings used to finance the purchase or construction of those assets. Restricted net assets are noncapital net assets that must be used for a particular purpose, as specified by those creditors, grantors, or contributors external to the Hospital, including amounts deposited with trustees as required by revenue bond indentures. Unrestricted net assets are remaining net assets that do not meet the definition of the other two categories of net assets. Designated funds remain under the control of the board of trustees, which may, at its discretion, later use the funds for other purposes.

Net Patient Service Revenue - Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactively calculated adjustments arising under reimbursement agreements with third-party payors are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods, as final settlements are determined (see Note 5). In addition to contractual provisions, net patient service revenue is presented net of provision for bad debts.

Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. Management believes that it is in compliance with all applicable laws and regulations. Final determination of compliance with such laws and regulations is subject to future government review and interpretation. Violations may result in significant regulatory action including fines, penalties, and exclusion from the Medicare and Medicaid programs.

Note 1 - Nature of Business and Significant Accounting Policies (Continued)

Charity Care - The Hospital provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than established rates. Because the Hospital does not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue.

Operating Revenues and Expenses - The Hospital's statement of revenues, expenses, and changes in net assets distinguishes between operating and nonoperating revenues and expenses. Operating revenues result from exchange transactions associated with providing healthcare services - the Hospital's principal activity. Operating expenses are all expenses incurred to provide healthcare services, other than financing costs. Nonoperating activities, including investment income and contributions received for purposes other than capital asset acquisition, and interest expense, are reported as nonoperating revenue and expense.

Tax Levy - Property taxes that are both measurable and available for use to finance operations are recorded as nonoperating revenue when earned. Property taxes are levied and are intended to finance the Hospital's activities. Amounts levied are based on assessed property values.

Note 2 - Deposits and Investments

Michigan Compiled Laws Section 129.91 (Public Act 20 of 1943, as amended) authorizes local governmental units to make deposits and invest in the accounts of federally insured banks, credit unions, and savings and loan associations that have offices in Michigan. The local unit is allowed to invest in bonds, securities, and other direct obligations of the United States or any agency or instrumentality of the United States; repurchase agreements; bankers' acceptances of United States banks; commercial paper rated within the two highest classifications, which matures not more than 270 days after the date of purchase; obligations of the State of Michigan or its political subdivisions, which are rated as investment grade; and mutual funds composed of investment vehicles that are legal for direct investment by local units of government in Michigan.

The investment policy adopted by the board is in compliance with Public Act 20 of 1943 and authorizes the Authority to invest in the investments listed above. The Hospital's deposits and investment policies are in accordance with statutory authority.

Note 2 - Deposits and Investments (Continued)

The Hospital's cash and investments are subject to several types of risk, which are examined in more detail below for the year ended June 30, 2008:

Custodial Credit Risk of Bank Deposits - Custodial credit risk is the risk that in the event of a bank failure, the Hospital's deposits may not be returned to it. The Hospital does not have a deposit policy for custodial credit risk. At year end, the Hospital had $5,347,284 of bank deposits (certificates of deposit, checking, and savings accounts) that were uninsured and uncollateralized. The Hospital believes that due to the dollar amounts of cash deposits and the limits of FDIC insurance, it is impractical to insure all deposits. As a result, the Hospital evaluates each financial institution with which it deposits funds and assesses the level of risk of each institution; only those institutions with an acceptable estimated risk level are used as depositories.

Custodial Credit Risk of Investments - Custodial credit risk is the risk that, in the event of the failure of the counterparty, the Hospital will not be able to recover the value of its investments or collateral securities that are in the possession of an outside party. The Hospital does not have a policy for custodial credit risk. All of the Hospital's investment securities were insured and registered, with securities held by the counterparty in the Hospital's name. The Hospital does have investments held by an investment manager that is not considered a financial institution. They are disclosed below:

Type of Investment	Carrying Value	How Held
Edward Jones	$ 201,009	Counterparty

Interest Rate Risk - Interest rate risk is the risk that the value of investments will decrease as a result of a rise in interest rates. The Hospital's investment policy does not restrict investment maturities. At year end, the maturities of investments are as follows:

Investment	Fair Value	Weighted Average Maturity
Federal Farm Bank	$ 301,469	3.48 years
FHLB	2,319,152	2.44 years
FHLMA	149,180	4.95 years
FNMA	553,780	3.81 years
Freddie Mac	409,878	5.30 years
GNMA	7,497	7.48 years

Credit Risk - The Hospital held approximately $140,000 of corporate stock as of June 30, 2008. These stocks were gifted to the Hospital in previous years. Inherently, stock has significant market risk and can fluctuate dramatically from day to day. The Hospital's investment policy does not speak to stock investments.

Note 2 - Deposits and Investments (Continued)

State law limits investments in commercial paper to the top two ratings issued by nationally recognized statistical rating organizations. The Hospital's investment policy limits its investment choices to legally permissible instruments. As of June 30, 2008, the credit quality ratings of debt securities (other than the U.S. government) are as follows:

Investment	Fair Value	Rating	Rating Organization
Federal Farm Bank	$ 301,469	AAA	Standard & Poor's
FHLB	2,319,152	AAA	Standard & Poor's
FHLMA	149,180	AAA	Standard & Poor's
FNMA	553,780	AAA	Standard & Poor's
Freddie Mac	409,878	AAA	Standard & Poor's
GNMA	7,497	AAA	Standard & Poor's

Concentration of Credit Risk - The Hospital's investment policy places no limits on the amount it may invest in any one issuer.

For comparative purposes, the following is presented for the year ended June 30, 2007:

Custodial Credit Risk of Bank Deposits - Custodial credit risk is the risk that in the event of a bank failure, the Hospital's deposits may not be returned to it. The Hospital does not have a deposit policy for custodial credit risk. At June 30, 2007, the Hospital had $11,118,299 of bank deposits (certificates of deposit, checking, and savings accounts) that were uninsured and uncollateralized. The Hospital believes that due to the dollar amounts of cash deposits and the limits of FDIC insurance, it is impractical to insure all deposits. As a result, the Hospital evaluates each financial institution with which it deposits funds and assesses the level of risk of each institution. Only those institutions with an acceptable estimated risk level are used as depositories.

Custodial Credit Risk of Investments - Custodial credit risk is the risk that, in the event of the failure of the counterparty, the Hospital will not be able to recover the value of its investments or collateral securities that are in the possession of an outside party. The Hospital does not have a policy for custodial credit risk. All of the Hospital's investment securities were insured and registered, with securities held by the counterparty in the Hospital's name. The Hospital does have investments held by an investment manager that is not considered a financial institution. They are disclosed below:

Type of Investment	Carrying Value	How Held
Edward Jones	$ 149,728	Counterparty

Note 2 - Deposits and Investments (Continued)

Interest Rate Risk - Interest rate risk is the risk that the value of investments will decrease as a result of a rise in interest rates. The Hospital's investment policy does not restrict investment maturities. At June 30, 2007, the maturities of investments are as follows:

Investment	Fair Value	Weighted Average Maturity
Fannie Mae	$ 296,281	1.12 years
Federal Farm Bank	428,280	4.03 years
FHLB	2,667,057	2.54 years
FHLMA	248,412	4.63 years
FNMA	722,314	3.56 years
Freddie Mac	590,691	4.57 years
GNMA	10,414	8.48 years

Credit Risk - The Hospital held approximately $500,000 worth of corporate stock as of June 30, 2007. These stocks were gifted to the Hospital in previous years. Inherently, stock has significant market risk and can fluctuate dramatically from day to day. The Hospital's investment policy does not speak to corporate stock investments.

State law limits investments in commercial paper to the top two ratings issued by nationally recognized statistical rating organizations. The Hospital's policy states that all investment grade securities shall be limited to bonds rated AAA, AA, or A by Standard & Poor's or Moody's rating systems. As of June 30, 2007, the credit quality ratings of debt securities (other than the U.S. government) are as follows:

Investment	Fair Value	Rating	Rating Organization
Fannie Mae	$ 296,281	AAA	Standard & Poor's
Federal Farm Bank	428,280	AAA	Standard & Poor's
FHLB	2,667,057	AAA	Standard & Poor's
FHLMA	248,314	AAA	Standard & Poor's
FNMA	722,314	AAA	Standard & Poor's
Freddie Mac	590,691	AAA	Standard & Poor's

Concentration of Credit Risk - The Hospital's investment policy places no limits on the amount it may invest in any one issuer.

Note 3 - Patient Accounts Receivable

The details of patient accounts receivable are set forth below:

	2008	2007
Patient accounts receivable	$ 13,367,332	$ 16,297,105
Less:		
Allowance for uncollectible accounts	(2,300,000)	(4,100,000)
Allowance for contractual adjustments	(3,700,000)	(6,200,000)
Net patient accounts receivable	$ 7,367,332	$ 5,997,105

The Hospital is located in South Haven, Michigan. The Hospital provides services without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. The mix of receivables from patients and third-party payors is as follows:

	Percentage	
	2008	2007
Medicare	16	19
Blue Cross/Blue Shield of Michigan	8	10
Medicaid	19	20
Commercial insurance and HMOs	21	25
Self-pay	36	26
Total	100	100

Note 4 - Capital Assets

Cost of capital assets and related depreciable lives as of June 30, 2008 are summarized below:

	2007	Additions	Transfers	Retirements	2008	Depreciable Life - Years
Land and land improvements	$ 979,209	$ 4,468	$ -	$ -	$ 983,677	3-25
Building and improvements	20,460,660	961,033	7,121,989	-	28,543,682	10-40
Furniture, fixtures, and equipment	12,580,857	2,126,097	-	(285,471)	14,421,483	6-20
Construction in progress	1,925,847	5,448,484	(7,121,989)	-	252,342	-
Total	35,946,573	$ 8,540,082	$ -	$ (285,471)	44,201,184	
Less accumulated depreciation:						
Land and land improvements	312,597	$ 30,375	$ -	$ -	342,972	
Building and improvements	10,840,140	1,064,311	-	-	11,904,451	
Furniture, fixtures, and equipment	7,461,341	1,747,271	-	(148,867)	9,059,745	
Total depreciation	18,614,078	$ 2,841,957	$ -	$ (148,867)	21,307,168	
Net carrying amount	$ 17,332,495				$ 22,894,016	

Note 4 - Capital Assets (Continued)

Cost of capital assets and related depreciable lives as of June 30, 2007 are summarized below:

	2006	Additions	Transfers	Retirements	2007	Depreciable Life - Years
Land and land improvements	$ 918,195	$ 82,130	$ 9,150	$ (30,266)	$ 979,209	3-25
Building and improvements	20,573,331	192,870	13,165	(318,706)	20,460,660	10-40
Furniture, fixtures, and equipment	11,724,455	2,703,463	1,682	(1,848,743)	12,580,857	6-20
Construction in progress	128,971	1,820,873	(23,997)	-	1,925,847	-
Total	33,344,952	$ 4,799,336	$ -	$ (2,197,715)	35,946,573	
Less accumulated depreciation:						
Land and land improvements	314,489	$ 28,374	$ -	$ (30,266)	312,597	
Building and improvements	10,275,181	956,721	-	(391,762)	10,840,140	
Furniture, fixtures, and equipment	7,711,203	1,522,019	-	(1,771,881)	7,461,341	
Total depreciation	18,300,873	$ 2,507,114	$ -	$ (2,193,909)	18,614,078	
Net carrying amount	$ 15,044,079				$ 17,332,495	

Total depreciation expense for the years ended June 30, 2008 and 2007 was $2,841,957 and $2,507,114, respectively. Of those amounts, $2,801,266 and $2,439,878 was included in operations and $40,691 and $67,236 was included in nonoperating expenses related to the medical office building in 2008 and 2007, respectively.

The Hospital began the Shoreline Wellness and Rehabilitation Center project during the fiscal year ended June 30, 2007. The project is expected to cost approximately $8.3 million. Sources of funds include 2007 bond proceeds of $4.5 million, donations of $1.25 million, and internal funds of $2.55 million. At June 30, 2008, a minimal amount of commitments remains on the project.

Note 5 - Estimated Third-party Payor Liability

The Hospital has agreements with third-party payors that provide for payments to the Hospital at amounts different from its established rates. Approximately 69 percent of the Hospital's net patient service revenue is received from the Medicare, Medicaid, and Blue Cross/Blue Shield of Michigan programs. Subsidiaries of the Hospital have agreements with third-party payors that provide for reimbursement at amounts different from established rates. A summary of the basis of reimbursement with these third-party payors is as follows:

- **Medicare** - Inpatient, acute-care services rendered to Medicare program beneficiaries are paid at prospectively determined rates per discharge. These rates vary according to a patient classification system based on clinical, diagnostic, and other factors. Outpatient and homecare services related to Medicare beneficiaries are reimbursed based on a prospectively determined amount per episode of care.

Note 5 - Estimated Third-party Payor Liability (Continued)

- **Medicaid** - Inpatient, acute-care services rendered to Medicaid program beneficiaries are also paid at prospectively determined rates per discharge. Capital costs relating to Medicaid patients are paid on a cost-reimbursement method. Rural health clinic services are paid based upon a limited-cost reimbursement methodology. All other outpatient and physician services are reimbursed on an established fee-for-service methodology.
- **Blue Cross/Blue Shield of Michigan** - Under an agreement with Blue Cross/Blue Shield of Michigan, the Hospital is paid based on a cost-plus-reimbursement methodology.

Cost report settlements result from the adjustment of interim payments to final reimbursement under these programs, which are subject to audit by fiscal intermediaries. Although these audits may result in some changes in these amounts, they are not expected to have a material effect on the accompanying financial statements.

Note 6 - Accrued Liabilities

The details of accrued liabilities at June 30, 2008 and 2007 are as follows:

	2008	2007
Payroll and related items	$ 497,918	$ 525,376
Compensated absences	793,100	689,265
Interest	121,963	68,154
Professional and other liability claims (Note 9)	500,000	500,000
Self-insurance liability for medical claims (Note 9)	9,000	149,000
Other	118,595	95,051
Total accrued liabilities	$ 2,040,576	$ 2,026,846

Note 7 - Long-term Debt

Long-term liability activity for the years ended June 30, 2008 and 2007 was as follows:

2008	Beginning Balance	Current Year Additions	Current Year Reductions	Ending Balance	Amounts Due Within One Year
Bonds - Series 2007	$ 4,500,000	$ -	$ (300,000)	$ 4,200,000	$ 300,000
Bonds - Series 2004	5,680,001	-	(473,333)	5,206,668	473,333
Capital lease obligation	1,334,305	-	(279,476)	1,054,829	272,645
Total	$ 11,514,306	$ -	$ (1,052,809)	$ 10,461,497	$ 1,045,978
2007					
Bonds - Series 2007	$ -	$ 4,500,000	$ -	$ 4,500,000	$ 300,000
Bonds - Series 2004	6,153,334	-	(473,333)	5,680,001	473,333
Capital lease obligation	-	1,438,824	(104,519)	1,334,305	273,726
Total	$ 6,153,334	$ 5,938,824	$ (577,852)	$ 11,514,306	$ 1,047,059

The bonds payable are summarized as follows:

- Series 2004 consisted of South Haven Community Hospital Authority revenue and revenue refunding bonds issued to pay off previous long-term debt and to finance a renovation project. The bonds bear interest ranging from 4.65 percent to 5.4 percent. Principal payments of $473,333 are due each November 1 beginning in 2004 through 2018. Interest payments are due semiannually on November 1 and May 1 of the same period. The bonds are collateralized by net revenue of the Hospital.
- Series 2007 consisted of South Haven Community Hospital Authority revenue bonds issued to finance a construction project. The bonds bear interest ranging from 4.45 percent to 4.95 percent. Principal payments of $300,000 are due each January 31, beginning in 2008 through 2022. Interest payments are due semiannually on January 31 and July 31 of the same period. The bonds are collateralized by net revenue of the Hospital.

Note 7 - Long-term Debt (Continued)

The capital lease obligation is summarized as follows:

- A CT scanner leased through GE Capital Public Finance, Inc. requires monthly payments of $27,340, beginning in December 2006 and ending in January 2012, including imputed interest of 4.5 percent, and is collateralized by equipment. The assets and liabilities under capital lease are recorded at the lower of the present value of the minimum lease payments or fair value of the assets. The carrying value of equipment under the capital lease obligation is $1,438,824 with accumulated depreciation of $431,647 and $143,882 at June 30, 2008 and 2007, respectively. The CT scanner is depreciated over the related lease term. Depreciation of assets under capital lease is included in depreciation expense for 2008 and 2007 and was $287,765 and $143,882, respectively.

The following is a schedule by years of bond principal and interest as of June 30, 2008:

Years Ending June 30	Long-term Debt		Capital Lease Obligation	
	Principal	Interest	Principal	Interest
2009	$ 773,333	$ 426,685	$ 272,645	$ 41,857
2010	773,333	395,788	299,374	28,709
2011	773,333	363,665	313,120	14,962
2012	773,333	330,044	169,690	2,126
2013	773,333	295,167	-	-
2014-2018	3,866,665	917,283	-	-
2019-2022	1,673,338	159,780	-	-
Total payments	$ 9,406,668	$ 2,888,412	$ 1,054,829	$ 87,654

Note 8 - Tax-deferred Annuity Retirement Plan

The Hospital provides pension benefits to all of its full-time employees though a defined contribution plan. In a defined contribution plan, benefits depend solely on amounts contributed to the plan, plus investment earnings. Under the plan, the Hospital contributes amounts matching employees' contributions up to 5 percent of base pay for participating employees. In accordance with these requirements, the Hospital contributed $355,366 during the current year and employees contributed $719,180. For the year ended June 30, 2007, the Hospital contributed $329,029 and employees contributed $592,401.

Note 9 - Risk Management

The Hospital is exposed to various risks of loss related to property loss, torts, errors and omissions, employee injuries (workers' compensation), as well as medical benefits provided to employees. The Hospital has purchased commercial insurance for malpractice and general liability claims, and participates in the Michigan Hospital Association risk pool for claims relating to workers' compensation. During 2008, the Hospital purchased commercial insurance for employee medical claims. In previous years, the Hospital was self-insured for employee medical claims. Changes in the estimated liability (included in accrued liabilities) for the past two fiscal years were as follows:

	2008	2007
Estimated liability - Beginning of year	$ 149,000	$ 149,000
Estimated claims incurred, including changes in estimates	2,571,017	1,808,875
Claim payments	(2,711,017)	(1,808,875)
Estimated liability - End of year	$ 9,000	$ 149,000

Malpractice - The Hospital is insured against potential professional liability claims under a claims-made policy, whereby only the claims reported to the insurance carrier during the policy period are covered regardless of when the incident giving rise to the claim occurred. Under the terms of the policy, the Hospital must pay a deductible toward the cost of litigating or settling any asserted claims. In addition, the Hospital bears the risk of the ultimate costs of any individual claim exceeding the policy limits for claims asserted in the policy year.

Should the claims-made policy not be renewed or replaced with equivalent insurance, claims based on occurrences during the claims-made term, but reported subsequently, will be uninsured.

The Hospital has been named a defendant in several malpractice suits. All cases involving the Hospital are in the very early stages and it would be premature to evaluate the likely outcome, amount of settlement, if any, or whether settlements could exceed the insurance coverage. Management intends to vigorously defend these suits and does not expect any unfavorable impact.

The accrual for estimated malpractice claims was $500,000 at June 30, 2008 and 2007. Management believes, after considering legal counsel's evaluations of all actions and claims, that insurance coverage and accruals for estimated losses are adequate to cover expected settlements.

Note 10 - Nonoperating Income and Expense

The details of nonoperating income are shown below:

	2008	2007
Income on investments limited as to use	$ 437,558	$ 474,760
Net increase in fair value of investments	126,740	207,427
Unrestricted investment income	62,083	66,149
Medical office building - Net loss	(49,694)	(114,151)
Disposal of equipment - Net gain (loss)	1,946	(606)
Contributions restricted for capital expenditures	-	1,035,383
Tax levy	373,415	372,240
Interest expense	(507,255)	(309,638)
Other	1,513	19,017
Net nonoperating income	$ 446,306	$ 1,750,581

Note 11 - Charity Care and Community Benefit

Charges excluded from revenue under the Authority's charity care policy were $597,646 and $395,427 for 2008 and 2007, respectively.

In addition, under arrangements with various governmental insurance programs, the Hospital provides significant care to the local indigent population for which reimbursement for services rendered is generally less than the cost of providing such services. As part of its obligation to the local communities, the Hospital also provides numerous other services that benefit the communities and are generally performed at no charge.

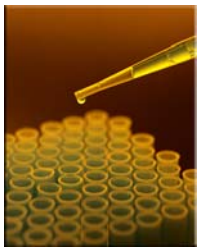
South Haven Community Hospital Authority

Report to the Board of Directors and Finance Committee

June 30, 2008








plante moran

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Communication of Internal Control Related Matters and Other Matters

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To the Board of Directors and Finance Committee
South Haven Community Hospital Authority

In planning and performing our audit of the financial statements of South Haven Community Hospital Authority (the "Authority") as of and for the year ended June 30, 2008, in accordance with auditing standards generally accepted in the United States of America, we considered the Authority's internal control over financial reporting (internal control) as a basis for designing our auditing procedures for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Authority's internal control. Accordingly, we do not express an opinion on the effectiveness of the Authority's internal control. Due to recently enacted audit standards, our consideration and assessment of internal controls were significantly more in-depth than in prior years.

Our consideration of internal control was for the limited purpose described in the preceding paragraph and would not necessarily identify all deficiencies in internal control that might be significant deficiencies or material weaknesses.

A control deficiency exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent or detect misstatements on a timely basis. A significant deficiency is a control deficiency, or combination of control deficiencies, that adversely affects the Authority's ability to initiate, authorize, record, process, or report financial data reliably in accordance with generally accepted accounting principles such that there is more than a remote likelihood that a misstatement of the Authority's financial statements that is more than inconsequential will not be prevented or detected by the Authority's internal control.

To the Board of Directors and Finance Committee
South Haven Community Hospital Authority

This communication is intended solely for the information and use of management, the board of trustees, the finance committee, and others within the Authority and is not intended to be, and should not be, used by anyone other than these specified parties.

Thank you for the opportunity to be of service to the Authority. Should you wish to discuss any of the items included in this report, we would be happy to do so.

Plante & Moran, PLLC

September 5, 2008

Exhibit A
Cash Related Processes - Significant Deficiency

Currently, the controller has administrative access to online banking, the ability to make transfers, post manual journal entries to cash, and also prepares all bank reconciliations except for the receiving account. Manual journal entries are not being formally reviewed. We recommend independent review of manual journal entries, especially cash related entries to assure they are being recorded properly. The Authority should consider limiting access and establishing an approval or review process to minimize the risk associated with posting manual journal entries and reconciliations.

Also, there are no sufficient controls related to online banking, including transfers and payments to vendors. Those with access can enter the bank account and routing number they would like to send payment to. We recommend working with the bank to set up some controls in this area. One possible solution is to create limits as to the amount that can be withdrawn daily. Another solution would be to set up the website so new account information cannot be entered. Wire transfers and online payments should be limited to a drop-down list of previously approved accounts or vendors. We further recommend an approval process in which the bank would receive an authorization form to set up new vendors, approved by an authorized signer that does not have access to the online banking.

During our review of the reconciliation of the receiving account, we noted numerous reconciling items. The reconciling items occur when payment is received into the account, but it is not posted to the general ledger, or vice versa. This often happens in relation to third-party payor payments as the payment and voucher listing patient application are received separately. We noted one receipt in May of $98,400 had not been recorded yet, and still had not been at the time of testing, because a voucher was not received. We also noted reconciling items go back several months, with smaller amounts going back almost a year. There was also an unknown variance of approximately $75,000. These items should be cleared up on a timelier basis in order to catch errors and to reflect an accurate cash balance. After year end, the responsibility of this reconciliation was passed on to an employee in the patient accounts area, which should lead to cleanup of reconciling items, based on her involvement in the area.

Exhibit B
Accounts Payable - Significant Deficiency

During our testing of accounts payable, we noted several errors regarding the timing of recognition of invoices. Invoices were found that were improperly included in accounts payable, as well as improperly excluded from accounts payable. Based on our testing, we had management review the listing of invoices accrued for at June 30, 2008, as well as invoices entered after the month-end close process. Based on management's review and our testing, we proposed an entry to reduce accounts payable and expense by $21,281.

One concern in this area is that there seemed to be a lack of understanding by the AP clerk as to which period an invoice should be recorded in. Management should provide some education on the significance of recording invoices based on the service date, or the date of receipt of tangible items. An additional suggestion in this area is to review the materials management system for items received but not yet invoiced. A second issue was a result of the timeliness of when the AP clerk is receiving invoices with approvals from department heads. Some recommendations for this are as follows:

- Enter invoices before sending them to the department heads, but they would not be allowed for payment until received back with approval
- Log invoices before sending them to department heads, and then follow up on a regular basis
- Send out a communication to the department heads directing them to return all approved invoices and check requests by a certain date that would allow time for the AP clerk to enter them

Exhibit C
Other Suggestions for Increased Reliability - Control Deficiencies

The items presented below were identified as areas for potential improvement in the Authority's internal control procedures. The vulnerability to internal or external fraud-related activities continues to be a significant focus for management and board members of nonprofit organizations. It is strongly believed that all organizations (small and large) have some level of risk in this area and even having the "best practices" in place will not necessarily prevent the occurrence of their unfortunate activity. Through many recent conversations with our clients regarding their susceptibility to fraud, it was noted the most important element necessary to reduce the risk of fraud is to have a sound organizational structure, which includes sound accounting and internal control policies and procedures (in the eyes of their employees).

General

- As mentioned within Exhibit A, there is no review of manual journal entries. We recommend that manual journal entries be reviewed by a second person for understanding of the entry as well as verifying the accuracy of amounts posted. Review should be documented by a sign-off and date.

- Budgetary systems are a key component in allowing management to see the areas where spending and revenue have deviated from the amounts originally planned. It also places financial responsibility on the department heads. We recommend creating procedures for review of revenue and expense items, requiring timely reporting back to management on variances from budget. Explanations on variances should be reviewed by management and retained for documentation. It is the current plan of management to implement these procedures for fiscal year 2009.

Accounts Receivable and Revenue

- Due to the number of steps in the billing process, it generally takes a couple of days from the service date before the charge is posted to the general ledger. At the end of the month, this creates a couple of days of revenue that are posted in the incorrect period. Based on our analysis of June charges that were posted in July, we proposed an entry of $40,000. We recommend that management perform a similar analysis on a regular basis to ensure revenue is recorded in the correct period.

- The Authority has made significant improvements in many areas of the revenue cycle. There is still room for improvement. Overall days revenue in accounts receivable has decreased from 111 in 2006, to 91 in 2007, and 72 in 2008. This is still higher than average compared to other hospitals. We also noticed an increase in days in accounts receivable when looking at self-pay and commercial accounts.

- We noticed cashiers receive payments, as well as apply them to the patient account. These responsibilities should be done by separate employees for proper segregation of duties. Receipts should be logged and deposited by one employee, and application to the patient account should be done by a second employee from the log or copies. This allows for the application to be reconciled to the original log, in order to account for all receipts. The risk is reduced based on the fact that most third-party payments are received electronically, and actual cash receipts are minimal.

- It has been three years since the Authority has had a review of the chargemaster. Management is currently looking for a vendor to complete a review during the fiscal year. We recommend this process be done on an annual basis, or that the Authority subscribe to a chargemaster service which would update it on a more frequent basis. This will allow for more accurate billing and in some cases improved revenue capturing.

Property, Plant, and Equipment

At the end of the year, reports were sent to departments related to fixed assets recorded in the general ledger in their area. The intent was for them to indicate which assets no longer exist at the hospital, so the records could be cleaned up. We found one listing that was completed by the IT department, but was not transferred into the system. Because most of the assets were fully depreciated, the net effect of the disposals would have had a minimal effect on the financial statements. The accounting department also found a keying error in the amount of an asset. They then went back and reviewed all asset additions into the system over the last two years. Several errors were found though they netted to an insignificant amount. We recommend that a review process be put in place to verify all additions and disposals are being recorded appropriately.

Payroll

Currently, the controller and payroll clerk are able to make changes to hours and rates within the payroll system. We recommend implementing a policy and establishing a procedure whereby an individual who has read-only access to the payroll module could review a system-generated report of all manual inputs or changes made during the payroll process.

Exhibit D
IT General Controls - Significant Deficiencies and Control Deficiencies

Significant Deficiency - Access Termination

Information technology (IT) is not immediately notified of terminations. This enables terminated employees to access applications after termination providing the opportunity for the improper manipulation of company data. It was noted that once IT was notified, access was immediately disabled.

We recommend implementing a process whereby IT is immediately notified upon termination of an employee by human resources (HR). This process should include a paper or electronic form that documents the termination details. This form should allow IT to document when access was terminated and should be retained by either HR or IT.

For key accounting and operational staff, transaction level logging should be enabled prior to and immediately after the termination date. Transactions of the user should be reviewed to ensure that unauthorized activity is detected and reviewed.

Significant Deficiency - Segregation of Duties/Administrative Access

Individuals with full administrative access have access to post transactions in the core financial applications. Information systems staff have administrative privileges to both the network and core financial applications. John Kirshman and Dennis Sorenson are named as having privileges to both. A generic user name (tech) was noted on the network administrator screen shot.

Individuals with full administrative access (e.g., access to administer access, upload new versions, etc.) should not have access to post transactions in the core financial systems. This allows for proper segregation of duties and ensures that user access and accountability controls are not comprised. If it is necessary (due to lack of staff) to allow a user with both levels of access, the activities should be logged and independently reviewed.

Control Deficiencies

New User Access, Access Changes, and Access Review

A new user and user access change form is not available to document details for user access. Additionally, an annual access review is not performed. A formal process through a paper or electronic form that documents access, access changes, and necessary approvals should be put in place. IT should furthermore document the new access or changes to access. The forms should be retained either by IT or HR for the duration of the employee's/user's employment. A formalized process will ensure that an employee's access is commensurate with the employee's job function. Review should occur at least annually. Reviews should be conducted by IT in conjunction with supervision or HR. Any exceptions should be clearly documented and retained.

Authentication Controls - Network Application

Network users do not have unique user IDs, password length is set to six characters, password complexity is not enforced, and unsuccessful log-in attempts are set to five. Network users should have unique usernames, password lengths should be set to seven characters or more, password complexity should be enforced, and unsuccessful log-in attempts should be set to three or less.

Backup Procedures

Backup tapes are not rotated to an offsite location at least five miles away. It is suggested that backup tapes be rotated to an offsite location at least five miles away to protect them from disaster at the primary location. The tapes should be clearly marked as to date/version and rotation.

Environmental Controls

Smoke detectors in the computer room are not available and the servers are not protected from water damage. It is recommended that fire detection and suppression devices be put in place as well as the servers being elevated at least three feet above floor level to maintain normal and efficient processing of servers and network devices.

Exhibit E
Medicare Advantage Plans - Informational

Over the past year, South Haven Community Hospital Authority has seen a significant shift from beneficiaries covered under traditional Medicare to Medicare Advantage plans. Medicare Advantage plans are paid by Medicare based on a monthly premium and then the plans are responsible for the healthcare received by the beneficiary. This shift from regular Medicare to Medicare Advantage plans can result in additional burdens and cost for providers due to having to bill multiple insurance companies for Medicare services. Unless the provider signs an agreement with the plan stating otherwise, the Medicare Advantage plan is required to reimburse the provider at their normal Medicare rates.

Medicare bad debts related to patients covered under Medicare Advantage plans are not reimbursed by Medicare on the cost report like patients covered under traditional Medicare. It is imperative that these bad debts not be included on the Medicare bad debt log which is submitted with the cost report as it could have a significant adverse impact on allowable bad debts due to sampling techniques utilized by the intermediaries.

Exhibit F
403(b) Plans - New Audit Requirements

The Department of Labor recently finalized revisions to the 2009 Form 5500. The revised Form 5500 will require many previously unaudited 403(b) plans to be audited. Currently, there is no Form 5500 filing requirement or a limited filing requirement for 403(b) plans (depending on certain facts and circumstances). The filing, if any, for a 403(b) plan does not require an audit or required schedules. During the past few years, the Internal Revenue Service and Department of Labor have identified problems with 403(b) plans and thus determined a change was needed.

Beginning with the 2009 plan year, organizations subject to the Employee Retirement Income Security Act of 1974 (ERISA) will generally be required to have their 403(b) plan's financial statements audited, if they have more than 100 eligible participants as of the beginning of the plan year. These audited financial statements will be a required attachment to the plan's Form 5500.

Although the first audit is not required until the 2009 plan year, Form 5500 requires the statement of net assets be fully comparative. Thus, 2008 financial information will need to be included in the plan's 2009 audited financial statements.

Historically, many 403(b) plans have not received a statement of net assets and activity statement at the plan level. Most 403(b) plans have often been treated more as individual account arrangements than a formal plan. This consolidated plan information needs to be available for 2008 to meet the presentation requirements of ERISA, and for 2009 for the auditors to complete the plan audit. Plan sponsors should contact their 403(b) investment custodian (typically an insurance company) to ensure that an investment statement will be available at the plan level for 2008 and years thereafter.

Engagement Scope

Our audit plan represented an approach responsive to the assessment of risk for South Haven Community Hospital Authority. Specifically, we designed our audit to:

- Express an opinion on the June 30, 2008 financial statements of the Authority
- Issue the required communications under SAS 114 to assist the board in overseeing management's financial reporting and disclosure process

Required Communications Under SAS114

Statement on Auditing Standards No. 114 (as amended) and other professional standards require the auditor to communicate certain matters to the board that may assist the board in overseeing management's financial reporting and disclosure process. Below, we summarize these required communications as they apply to the Authority.

Area	Comments
Auditors' Responsibilities Under Generally Accepted Auditing Standards (GAAS) Management has the responsibility for adopting sound accounting policies, for maintaining an adequate and effective system of accounts, for the safeguarding of assets, and for devising an internal control structure that will, among other things, help ensure the proper recording of transactions. The transactions that should be reflected in the accounts and in the financial statements are matters within the direct knowledge and control of management. Our knowledge of such transactions is limited to that acquired through our audit. Accordingly, the fairness of representations made through the financial statements is an implicit and integral part of management's responsibility. We may make suggestions as to the form or content of the financial statements or even draft them, in whole or in part, based on management's accounts and records. However, our responsibility for the financial statements is confined to the expression of an opinion on them. The financial statements are the responsibility of management. Our audit was designed in accordance with auditing standards generally accepted in the United States of America to provide reasonable, rather than absolute, assurance that the financial statements are free of material misstatement. As a part of our audit, we obtained an understanding of internal control sufficient to plan our audit and to determine the nature, timing, and extent of testing performed. However, we were not engaged to and we did not perform an audit of internal control over financial reporting. HIPAA and corporate compliance testing are beyond the scope of a financial statement audit.	We have issued an unqualified opinion on the financial statements of the Authority for the year ended June 30, 2008.
Materiality The concept of materiality is inherent in the work of an independent auditor.	An auditor places greater emphasis on those items that have, on a relative basis, more importance to the financial statements and greater possibilities of material error than with those items of lesser importance or those in which the possibility of material error is remote.
Critical Accounting Policies and Practices Auditing standards call for us to inform you regarding the initial selection of, and change in, significant accounting policies or their application. In addition, we are expected to inform you about the methods used to account for significant unusual transactions and the effect of significant accounting policies in controversial or emerging areas for which there is a lack of authoritative guidance or consensus.	For the year ended June 30, 2008, there were no significant changes in accounting policies or their applications.

Area	Comments
Authority's Accounting Principles We describe our judgments about the quality and acceptability of the accounting policies as applied in the Authority's financial reporting, including the consistency of the accounting policies and their application related to the financial statements and disclosures.	Management followed a consistent methodology with the prior year related to the establishment and maintenance of accounting policies and the related application of such policies in the preparation of financial statements. We believe that the underlying methodology used by the Authority is reasonable.
Accounting Estimates Accounting estimates are an integral part of the financial statements prepared by management and are based on management's current judgments. Auditing standards call for us to report to you about accounting estimates that are particularly sensitive because of their significance to the financial statements or because of the possibility that future events affecting them may differ markedly from management's current judgments. Further, we are expected to report to you about the process used by management in formulating particularly sensitive accounting estimates and about the basis for our conclusions regarding the reasonableness of those estimates.	We have provided additional information in the section titled "Areas of Audit Emphasis." The areas of particular significance include: • Net realizable value of patient revenue and accounts receivable (contractual and bad debt allowances) • Third-party payor settlements • Professional liability claims
The Adoption of, or a Change in, an Accounting Principle We communicate to the board the initial selection of, and any changes in, significant accounting principles or their application when the accounting principle or its application, including alternative methods of applying the accounting principle, has a material effect on the financial statements.	None
Significant or Unusual Transactions and Controversial or Emerging Areas We communicate to the board the methods used to account for significant unusual transactions and the effects of significant accounting policies in controversial or emerging areas for which there is a lack of authoritative guidance or consensus.	None
Significant Audit Adjustments Auditing standards call for us to report to you significant audit adjustments that, in our judgment, may not have been detected except through the auditing procedures we performed. We communicate to the board the information about adjustments arising from the audit (whether recorded or not) that could, in our judgment, either individually or in the aggregate, have a significant effect on the Authority's financial statements.	None
Uncorrected Possible Financial Statement Adjustments Considered by Management to be Immaterial Auditing standards also require us to inform the board about uncorrected possible financial statement adjustments identified by us during the current engagement and pertaining to the latest period presented, which were determined by management to be immaterial, both individually and in the aggregate, to the financial statements taken as a whole.	An entry was proposed that would have increased net patient revenue and accounts receivable by approximately $138,000 related to charges with a service date before June 30, 2008 that were posted after June 30, 2008. An entry was proposed to reduce accounts payable accruals and expenses by $34,118 for improper accruals. An entry was proposed to increase accounts payable and expenses by $12,837 for invoices relating to the year ended June 30, 2008 that were not accrued. An entry was proposed to increase inventory and revenue by $42,116 related to a physical inventory count done by the Hospital at year end, but was not adjusted in the general ledger.

Area	Comments
Fraud and Illegal Acts We report to the board fraud and illegal acts involving senior management and fraud and illegal acts (whether caused by senior management or other employees) that cause a material misstatement of the financial statements.	We are not aware of any matters that require communication.
Material Weaknesses in Internal Control We are required to communicate all material weaknesses in internal control which may have been identified during the course of our audit.	In connection with our audit of South Haven Community Hospital Authority, we reviewed internal controls for the purposes of obtaining a sufficient understanding of internal control to plan the audit and to determine the nature, timing, and extent of tests to be performed, during which we identified a material weakness related to contractual allowances. We were not engaged to, and we did not, perform audits of internal control over financial reporting.
Other Information in Documents Containing Audited Financial Statements	None
Disagreements with Management on Financial Reporting Matters	None
Serious Difficulties Encountered in Dealing with Management when Performing the Audit	None
Major Issues Discussed with Management in Connection with Initial Retention	None
Consultation with Other Accountants	We are not aware of any consultations with other accountants.
Other Material Written Communications with Management	Material written communications include various documents, including these communications. Some of the other significant written communications include the following: • Engagement letter between the Authority and Plante & Moran, PLLC • Management representation letter
Independence We are required to communicate, at least annually, the following to the board of trustees of the Authority: • Disclose, in writing, all relationships between Plante & Moran, PLLC and the Authority that, in our professional judgment, may reasonably be thought to bear on independence; • Confirm in writing that, in our professional judgment, we are independent of the Authority; and • Discuss with the board any matters that, in our professional judgment, may reasonably be thought to bear on our independence	We are not aware of any relationships between Plante & Moran, PLLC and the Authority that, in our professional judgment, may reasonably be thought to bear on our independence. Related to our audit of the financial statements of the Authority as of June 30, 2008 and for the year then ended, we are independent certified public accountants with respect to the Authority within the meaning of the applicable published pronouncements of the Independence Standards Board, and under Rule 101 of the American Institute of Certified Public Accountants' Code of Professional Conduct, its interpretations, and rulings.

Areas of Audit Emphasis

Key areas of audit emphasis and our judgments about the quality, not just the acceptability, of the Authority's accounting principles as applied in its financial reporting are summarized in the table below.

Area	Accounting Policy	Judgments and Sensitive Estimates	Comments on Quality of Accounting Policy and/or Application
Net Realizable Value of Patient Accounts Receivable	The Authority maintains accounting policies and procedures specifically related to these accounts adjusting amounts to reflect estimated amounts recoverable from patients and third-party payors based on paid claims experience.	Required allowances, reflecting the difference between standard rates and reimbursement, are based on aging and historical payment experience while considering current trends. Balance sheet valuation allowances are established for potential payment disallowances.	Management followed a consistent methodology with the prior year related to the establishment of allowances for doubtful accounts and contractual adjustments. We believe the underlying methodology used by the Authority is reasonable.
Estimated Settlements with Third-party Payors	The Authority establishes current year estimates of cost reports to be filed based on current year data and prior year cost report relationships. Estimates of prior year settlements are updated as additional information (including filed cost reports and interim settlements) becomes available.	These accounts represent amounts due to Medicare and other payors for the settlement of outstanding cost reports and amounts due to other payors for contract issues. Laws and regulations are complex and these estimates may change by a material amount in the near term. Changes to these amounts will be reflected in the statement of operations in the year of the change.	We believe the underlying methodology used by the Authority is reasonable.
Professional Liability Claims	The Authority establishes an estimate of the ultimate expense based on conclusions reached by in-house risk manager, legal counsel, and ongoing discussions related to incidents and reported claims with the Authority's insurance carrier.	Estimates recorded by the Authority are dependent upon underlying methods and analysis used by the insurance carrier and the accuracy of the underlying data.	Management has accrued its best estimate of these potential losses to the extent they fall within the limits of the insurance program or exceed the limits of insurance coverage. The loss reserve also includes estimates for claims and related legal expenses from unreported incidents arising from services provided to patients. We believe the underlying assumptions used by management and the resultant amounts are reasonable.

In addition, other areas of audit emphasis included:

- Cash and investments
- Accounts payable and purchasing cycle
- Fixed asset accounting and the applicable depreciation
- Debt and related testing of compliance with covenants
- Employee related accrued liabilities and payroll cycle

Healthcare Landscape

In planning and performing our audit of the financial statements of the Authority for the year ended June 30, 2008, we considered the overall accounting practices of the Authority as well as the risks the Authority is facing. The purpose of this section is to address some of these risks.

Reimbursement Update

Congress Introduces Administration's Medicare Trigger Bill

As required by the 2003 Medicare Modernization Act, House and Senate leaders introduced legislation proposed by the administration to respond to a Medicare funding warning issued by the program's trustees last April. According to the administration, the legislation (H.R. 5480/S. 2662) takes an approach to strengthening Medicare that includes limits on means testing for Part D premiums and medical liability costs, improved health information technology and electronic medical records, transparency in price and quality information, and incentives for providers to deliver and Medicare beneficiaries to choose high-quality, low-cost health care. At the same time, the president's fiscal year 2009 budget proposes more than $182 billion in cuts to the Medicare program over five years, $137 billion of which would come from hospitals.

Medicare Recovery Audit Contractors Coming to Michigan

CMS recently completed a three-year demonstration project in Florida, California, and New York which utilized outside contractors (Medicare Recovery Auditors) to review payments to Medicare providers. During this demonstration project, the Medicare Recovery Audits (RAC) identified $371 million of incorrect payments, with 96 percent of these payments being overpayment to provider and 4 percent being underpayments. The majority of the overpayments (85 percent) identified were from inpatient hospitals. It should be noted that many of these overpayments identified by the RACs are being appealed by the providers.

Based on the success of this program as determined by CMS, the demonstration project is being made permanent and expended and phased in across the entire nation with Michigan scheduled to be included in 2008. The permanent program included various changes from the demonstration project including, but not limited to, the following:

- RACs will not be allowed to review any claims prior to October 1, 2007 under the permanent program.
- RACs will only be allowed to look back three years (vs. four years under the demonstration project).
- RACs will now be allowed to review current year claims.
- The permanent program will set limits on medical record requests.
- RACs will have to reimburse the contingency fees received if they lose at any level of appeal. Under the demonstration project, RACs only had to repay their fee if they lost at first level of appeal.
- RACs must use certified coders under the permanent program.

President Proposes Nearly $200 Billion in Medicare, Medicaid Cuts

On February 4, 2008, President Bush proposed more than $182 billion in cuts to the Medicare program over five years, $64 billion of which would come from the hospital inpatient update. His fiscal year 2009 Department of Health and Human Services budget proposal would freeze Medicare updates for inpatient and outpatient services, inpatient rehab facilities, and long-term care hospitals from 2009-2011, with updates of market-basket minus 0.65 percent each year thereafter. Other Medicare reductions would include substantial cuts to indirect medical education and hospital capital and disproportionate share payments, an overall cut to hospitals through the establishment of a value-based purchasing program, and the elimination of payments for so-called "never events." The Medicaid program would be cut by more than $17 billion over five years.

Pay-for-performance

Quality of care improved in all five clinical areas measured as part of a recent pay-for-performance demonstration project conducted by CMS. In the project, the premier organization quality incentive, participating organizations were awarded $8.85 million in bonus payments for showing measurable improvements in quality of care. The bonus payments were awarded based on relevant quality measures. It is clear that Medicare will continue moving forward on pay-for-performance initiatives.

Office of Inspector General News

Physician Recruitment

OIG provides safe harbors on physician recruitment for hospitals designated in a health professional shortage area (HPSA). Information on HPSA can be found at the following website: bphc.hrsa.gov.

OIG Reports on 2006 Achievements

For fiscal year (FY) 2006, the HHS Office of Inspector General (OIG) reported savings and expected recoveries of nearly $38.2 billion for federal healthcare programs: $35.8 billion in implemented recommendations and other actions to put funds to better use, $789.4 million in audit receivables, and $1.6 billion in investigative receivables. Also for FY 2006, OIG reported exclusions of 3,425 individuals and entities for fraud or abuse involving federal healthcare programs and/or their beneficiaries, 472 criminal actions against individuals or entities that engaged in crimes against departmental programs, and 272 civil actions, which include False Claims Act (FCA) and unjust enrichment suits filed in federal district court, civil monetary penalties law (CMPL) settlements, and administrative recoveries related to provider self-disclosure matters. Source: OIG Semiannual Report, December 5, 2006.

Highlights of OIG's 2008 Work Plan

The following items have been highlighted in OIG's 2008 work plan:

- Hospital capital payments
- Medicare-dependent hospital program testing
- Medicare disproportionate share payments
- Provider bad debts
- Compliance with Medicare transfer policy
- Inpatient wage index
- Inpatient payments for new technologies
- Medicare secondary payor
- Medical appropriateness and coding of DRGs
- Inappropriate payments for diagnostic x-ray in hospital emergency rooms
- Oversight of Joint Commission Hospital Accreditation process
- Place of services errors
- Medicare payments for selected physician services
- Appropriateness of Medicare payments for polysomnography
- Assignment rules by Medicare providers
- Geographic areas with high utilization of ultrasound services
- Physician reassignment of benefits

Tax Developments

Hospitals Can Share Health IT with Physicians

In an Internal Revenue Service (IRS) ruling issued in early May 2007, the IRS noted that sharing health information technology with physicians would not jeopardize a not-for-profit hospital's tax-exempt status. Under this ruling, the following requirements must be met:

- An electronic health record arrangement requires that the hospital and the physician comply with electronic health record regulations issued by the Department of Health and Human Services.
- The arrangement must grant to the hospital, as permitted by the law, access to all electronic medical records created by the physician.
- Participation must be open to all of the hospital's medical staff physicians.
- The hospital must provide the same level of subsidy to all of its medical staff physicians unless the level of the subsidy is related to the difference in the healthcare needs of the community and not based on differences in referrals.

IRS Initiative Targets Not-for-profit Compensation Practices

Under the new Tax-exempt Compensation Enforcement Project, the IRS will be requesting information from approximately 2,000 charities and foundations to review information and supporting documents on compensation practices and policies for specific executives. The IRS will also be reviewing insider transactions such as leasing arrangements to officers and others in the hospital.

Uncompensated Care Update

United States hospitals provided $28.8 billion in uncompensated care in 2005, up from $26.9 billion, or 7.1 percent from 2004. Since 2000, uncompensated care has increased 25 percent or $5.3 billion. The survey, issued by American Hospital Association, is valued at cost of providing services for all bad debts and charity care and does not include amounts of Medicare and Medicaid reimbursement, which are below the cost of providing services to Medicare and Medicaid participants. According to the survey, Medicare and Medicaid underpaid hospitals by $15.5 billion and $9.8 billion, respectively.

Accounting and Auditing Update

New Accounting Standards

Health Care Audit Guide - The AICPA Health Care task force is currently evaluating the Health Care Audit Guide as part of a comprehensive overhaul of the 1996 document. A draft of the guide is expected to be released for comments possibly in 2008. Key areas to be addressed include charity care reporting, accounting and reporting of derivatives, contributions, medical malpractice, accounting for transfers between unrelated hospitals, and new basic financial statement presentations.

Other New Accounting Rules Are as Follows:

FSP FAS 126-1 - Defines a "public" not-for-profit entity to include an entity on whose behalf a governmental entity has issued tax-exempt bonds (finance authority). This requires certain additional disclosures to be made in the financial statements.

SFAS 133 Implementation Guide Issue No. G26 - Provides additional guidance on accounting for hedging instruments for interest rates or cash flows (interest rate swaps). Hedges against variability in interest rates can only use hedge accounting if the swaps are based on the same benchmark index (LIBOR or Treasury obligations).